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STATE OF MICHIGAN

IN THE SUPREME COURT

AUDREY TROWELL,

Plaintiff-Appellee,

vs.

PROVIDENCE HOSPITAL AND MEDICAL CENTERS, INC.,

Defendant-Appellant.

Docket No. 154476

Court of Appeals No. 301576

Wayne County Circuit Court
No. 08-018282-NM

BRIEF OF *AMICUS CURIAE* WEST BRANCH REGIONAL MEDICAL CENTER

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Statement Regarding Jurisdiction

West Branch Regional Medical Center agrees with the parties' statements of the basis of jurisdiction.

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Statement of Interest

West Branch Regional Medical Center is a state-of-the-art facility providing specialized, acute medical care to Northeast Michigan—more specifically, Ogemaw County and the surrounding areas. Like defendant Providence Hospital and Medical Centers, Inc., West Branch Regional employs nursing assistants in the care and treatment of its patients. It is also currently litigating a case in which the plaintiff has alleged dueling ordinary-negligence and medical-malpractice claims related to a patient's alleged fall when positioning for an x-ray. The trial court in that case has reserved decision on whether the claim is for ordinary negligence or medical malpractice until trial.

The distinction between ordinary-negligence claims and medical-malpractice claims is a frequently litigated issue, particularly for medical facilities like West Branch Regional. So West Branch Regional is keenly interested in this Court's determination of the issues presented in this case and, more broadly, Michigan law on distinguishing medical-malpractice claims from ordinary-negligence claims.

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Statement of Question Presented

> Under Michigan law, Trowell's claim that a nurse's aide dropped her when assisting her in the ICU is for malpractice. Yet the Court of Appeals speculated that other, unpleaded facts could possibly make it an ordinary-negligence claim, e.g., dropping Trowell to answer a cell phone. The speculation stems from *Bryant* adopting an analytical step for distinguishing medical malpractice from ordinary negligence that conflicts with other case law and undermines tort-reform goals. Should this Court reverse the Court of Appeals misapplication of *Bryant* or, alternatively, grant leave to revisit *Bryant* and, ultimately, reverse?

Amicus curiae West Branch Regional Medical Center answers, "yes," the Court of Appeals' analysis is wrong under existing law, but this Court should revisit *Bryant* to clarify the law.

Plaintiff-appellee Audrey Trowell answers, no, arguing that, under existing case law, discovery is required to possibly determine the type of claim she has pleaded.

Defendant-appellant Providence Hospital and Medical Centers, Inc. answers, yes, arguing that, under existing case law, Trowell's claim is for medical malpractice only.

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Introduction

Parties to litigation should be able to know the ground rules from the outset. That's particularly true for medical-malpractice cases, which have specific procedural requirements and damages limitations. The Court of Appeals' opinion in this case is dangerous because it allows and encourages plaintiffs to conceal the nature of their claim. Vague pleading gets the plaintiff past an early dispositive motion based on the statute of limitations. And the concealment may continue beyond discovery. Indeed, based on the Court of Appeals' analysis, the parties may not know what type of case this is and what the ground rules are until the very end when a jury returns a verdict. That's unfair and unworkable.

In this case, the defendant is deprived of the value of a statute-of-limitations defense.[1] In other cases, the panel's opinion will impede settlement. Medical-malpractice actions are subject to a noneconomic damages cap; ordinary-negligence actions aren't. When plaintiffs demand $2.5 million in noneconomic damages (like Audrey Trowell does), the cap on noneconomic damages can put the parties in the same ballpark. But when an ordinary-negligence claim remains at issue, the parties aren't even playing the same game. Plaintiffs puff up the value of their claim. It deters settlement and undermines the intent of the damages cap.[2]

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[1] See *Larson v Johns-Manville Sales Corp*, 427 Mich 301, 311; 399 NW2d 1 (1986) (a primary purpose behind the statute of limitations is "protect[ing] defendants from having to defend against stale or fraudulent claims").

[2] See *Zdrojewski v Murphy*, 254 Mich App 50, 80; 657 NW2d 721 (2002) ("The purpose of the damages limitation was to control increases in health care costs by

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The Court of Appeals' opinion in this case is wrong under existing law. It should be reversed. But the root of the problem is this Court's decision in *Bryant v Oakpointe Villa Nursing Centre*. More specifically, the third part of the three-part analysis that *Bryant* established for distinguishing medical-malpractice claims from ordinary-negligence claims is a problem. It requires courts to determine "whether the claim raises questions of medical judgment beyond the realm of common knowledge and experience."[3]

The third step of *Bryant*'s analysis is wrong because (1) it's based on a misreading of precedent, (2) it contradicts this Court's case law, and (3) it leads to the unworkable slippery slope illustrated in the Court of Appeals' opinion in this case. *Bryant* aimed to clarify how courts should distinguish medical malpractice from ordinary negligence. But it erred in the process. And its error is what led the Court of Appeals panel in this case to ponder hypotheticals, like whether the aide who was assisting Trowell dropped her to answer a cell phone.

West Branch Regional has two alternative proposals on how to fix *Bryant*. The simplest is the best. This Court should eliminate *Bryant*'s third step. As a result, a claim would be for medical malpractice if (1) the defendant is capable of medical malpractice and (2) the claim pertains to an action that occurred within the course of a professional relationship. This will result in more claims being for malpractice. It comports with this Court's pre-1999 case law defining medical malpractice and the purpose of the

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reducing the liability of medical care providers, thereby reducing malpractice insurance premiums, a large component of health care costs.").

[3] *Bryant v Oakpointe Villa Nursing Centre*, 471 Mich 411, 422; 684 NW2d 864 (2004).

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procedural protections that the Legislature placed on medical-malpractice claims.[4] It also resolves the conflict between *Bryant* and other case law and it's far simpler to apply--indeed, in most cases (like this one) the parties don't dispute these two issues.

Statement of Facts

West Branch Regional accepts Providence Hospital's statement of facts.

Discussion

A. Under existing law, the Court of Appeals erred.

The only issue in this case is whether Trowell's claim is for medical malpractice or ordinary negligence. The difference between an ordinary-negligence claim and a medical-malpractice claim is something that parties fight over with increasing frequency. The reason for the fight is that the difference can have a dramatic impact on a case. Here, for example, the plaintiff's claim is time barred if it's for medical malpractice, but it's timely if it's for ordinary negligence. In other cases, the distinction determines the stakes or risk exposure. There's a cap on noneconomic damages for medical-malpractice actions. MCL 600.1483. But there's no cap when it's only an ordinary-negligence action.

[4] *Driver v Naini*, 490 Mich 239, 254; 802 NW2d 311 (2011) ("The legislative purpose behind the notice requirement [includes] reducing the cost of medical malpractice litigation ...." (citation omitted)); *Barnett v Hidalgo*, 478 Mich 151, 164; 732 NW2d 472 (2007) ("The purpose of the affidavits of merit is to deter frivolous medical malpractice claims ....").

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The Court of Appeals in this case tried to follow this Court's decision in *Bryant v Oakpointe Villa Nursing Centre*, 471 Mich 411; 684 NW2d 864 (2004), which set out a three-step process for "determining whether the nature of a claim is ordinary negligence or medical malpractice." *Id.* at 419. Under *Bryant*, courts must first determine whether the claim "is being brought against someone who, or an entity that, is capable of malpractice." *Id.* at 420. If so, they must ask two questions: "(1) whether the claim pertains to an action that occurred within the course of a professional relationship; and (2) whether the claim raises questions of medical judgment beyond the realm of common knowledge and experience." *Id.* at 422. If all three questions are answered, "yes," then the claim is for medical malpractice.

In this case, the answer to the first and second question is indisputably, "yes." Providence Hospital is capable of malpractice. MCL 600.5838a(1); *Adkins v Annapolis Hosp*, 420 Mich 87, 94-95; 360 NW2d 150 (1984); see also *Trowell v Providence Hosp*, 316 Mich App 680, 692 n.5 (2016) ("The parties did not address this issue in the trial court, nor do they on appeal …."). And, as the Court of Appeals stated, "[t]here is no dispute in this case that plaintiff's suit concerned an action that took place within the course of a professional relationship." *Trowell*, 316 Mich App at 687 n.3.

The panel struggled with the third step. It attributed the difficulty to "the complaint [being] fairly vague and lack[ing] elaboration in terms of describing and factually supporting the particular theories of negligence it sets forth …." *Trowell*, 316 Mich App at 695. Yet the panel also acknowledged that "[t]he gravamen of a lawsuit is

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determined by reading the complaint as a whole …." *Id.*, citing *Kuznar v Raksha Corp*, 272 Mich App 130, 134; 724 NW2d 493 (2006).

The Court of Appeals' decision in *Wiley v Henry Ford Cottage Hosp*, 257 Mich App 488; 668 NW2d 402 (2003) should have settled the point. The plaintiff claimed that her leg was cut when nurses moved her from the toilet to a wheelchair. The court held that her claim was for medical malpractice because "an ordinary layman lacks knowledge regarding the appropriate methods and techniques for transferring patients." *Id.* at 510. Notably, the court didn't delve into hypotheticals about what could have gone wrong, or how obvious any mistake could have been.

Wiley, though decided before *Bryant*, applied *Dorris v Detroit Osteopathic Hosp Corp*, 460 Mich 26; 594 NW2d 455 (1999), which much of *Bryant*'s analysis was based on. *Wiley* also relied on this Court's peremptory reversal in *Regalski v Cardiology Associates, PC*, 459 Mich 891; 587 NW2d 502 (1998). Elisabeth Regalski was injured when a technician moved her from her wheelchair onto an examination table so that he could perform a cardiac test. This Court peremptorily reversed and reinstated summary disposition for the defendant because the claim was for malpractice, not ordinary negligence. Again, the Court didn't start speculating about possible circumstances that would have made the mistake an obvious error.

Bryant didn't overrule *Wiley* and *Regalski*. And, until the decision in this case, unpublished opinions in cases involving patient falls were held to involve only medical-malpractice claims. See, e.g., *Groesbeck v Henry Ford Health Sys*, unpublished opinion per curiam of the Court of Appeals, issued Feb. 26, 2013 (Docket No. 307069); 2013 WL

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951090 (**Exhibit 1**) (claim against physical therapist was for medical malpractice because "[w]hile an ordinary layman may know that an elderly patient with impaired balance may fall, he is not likely to know when it is proper to assess that person's gait or what precautions to take to limit the risk of falling"); *Campins v Spectrum Health Downtown Campus*, unpublished memorandum opinion of the Court of Appeals, issued Sept. 9, 2004 (Docket No. 247024); 2004 WL 2009264 (**Exhibit 2**) (holding that a claim that "defendant's employee acted negligently in assisting [the plaintiff] in moving from the bathroom to her bed" was for medical malpractice only); *Lewandowski v Mercy Mem Hosp Corp*, unpublished opinion per curiam of the Court of Appeals, issued Dec. 2, 2003 (Docket No. 241046); 2003 WL 22850024 (**Exhibit 3**) (affirming summary disposition because the claim that the defendant's employees "negligently … attempt[ed] to have her stand against her physician's orders" "sounded in medical malpractice rather than ordinary negligence"). In addition to *Wiley* and *Regalski*, these unpublished opinion demonstrate that Trowell's argument that "the line of 'falling' and/or 'drop' cases in Michigan have **all** been held to sound in ordinary negligence"[5] is incorrect.

Though it cited and described *Wiley* without distinguishing it, the panel in this case didn't apply it. And it didn't discuss *Regalski*.

The panel's real struggle came from its speculation—something that neither *Wiley* nor *Regalski* engaged in. The panel acknowledges that medical judgment would be involved in determining how many people should assist a patient or "determining

[5] Plaintiff-Appellee Answer to Application, p. 18.

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the proper technique to use when holding and escorting a patient." *Id.* at 697, 699. But then it suggested alternative scenarios that aren't reflected in the complaint.

The panel suggested that the claim could be for ordinary negligence if there was a significant "weight differential" or the aide had a handicap or recent injury. *Id.* at 698. The complaint didn't allege that there was a weight differential, nor that the aide was encumbered in any way. The panel suggested that the claim could be for ordinary negligence if "the aide dropped [the plaintiff] because the aide decided to answer a cell phone call" or used "an extremely and ridiculously loose grip …" *Id.* at 700. But there is no mention of a cell phone or "ridiculously loose grip" in the complaint. As Providence Hospital's application explained, the Court of Appeals erred in allowing the **absence** of those factual allegations to effect the nature of the claim. See MCR 2.111(B)(1) ("A complaint must contain …: A statement of the facts, without repetition, on which the pleader relies in stating the cause of action, with the specific allegations necessary **reasonably to inform the adverse party of the nature of the claims** the adverse party is called on to defend …" (emphasis added)).

While the panel suggested that discovery could add clarity, it may not. What if Trowell testifies that the aide answered her cell phone or had a loose grip and the aide denies it? Under the Court of Appeals' method, the mystery of what type of case this is could remain unresolved until a jury returns a verdict. In fact, the trial court would have to submit special interrogatories to the jury to settle the cell phone or loose grip dispute. Only after the jury answered those interrogatories would the parties know what type of claim they had been litigating.

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The analysis was much simpler than the panel made it. Recall that the nature of a claim is determined by reading the complaint as a whole. *Trowell*, 316 Mich App at 695, citing *Kuznar*, 272 Mich App at 134; see also *Simmons v Apex Drug Stores, Inc*, 201 Mich App 250, 253; 506 NW2d 562 (1993); *Buhalis v Trinity Cont Care Servs*, 296 Mich App 685, 691-692; 822 NW2d 254 (2012). Trowell alleged that a nurse's aide was negligent when assisting her from her bed to the bathroom. "[A]n ordinary layman lacks knowledge regarding the appropriate methods and techniques for transferring patients." *Wiley*, 257 Mich App at 510.[6] It's also well established that Trowell's allegations related to Providence Hospital's staffing decisions—proper supervision, providing an adequate number of nurses, and properly training—are all medical-malpractice claims. See *Bryant*, 471 Mich at 428-429 (holding that alleged failures to train nurse's aides "involve[d] the exercise of professional judgment"); *Dorris*, 460 Mich at 47 (holding that "allegations concerning staffing decisions and patient monitoring involve questions of professional medical management" because "[t]he ordinary layman does not know the type of supervision or monitoring that is required for psychiatric patients in a

[6] Providence Hospital's supplemental brief nicely sets out some of the possibilities to illustrate this point. See Providence Hospital Supplemental Brief, p. 6 ("[W]hether a gait belt should be used; whether a walker was necessary; whether a wheelchair was required; whether two nurses were required, and if two nurses were necessary, whether both should hold onto the patient or if one should merely stand by … [T]he potential methods of assistance are extensive and vary from patient to patient, depending upon her condition.")

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psychiatric ward").[7] Trowell's claim is for medical malpractice only. The Court of Appeals erred in holding otherwise.

B. *Bryant*—a change is needed.

Though often described as a two-part test,[8] *Bryant* actually set out a three-step analysis. The first two steps are firmly rooted in Michigan law. The third isn't. And it's the third that led the Court of Appeals down the rabbit hole in this case.

1. Step one: Is the defendant capable of malpractice?

Bryant stated that "[t]he first issue in any purported medical malpractice case concerns whether it is being brought against someone who, or an entity that, is capable of malpractice." 472 Mich at 420. That has to be part of the analysis. The logic is inescapable. If the defendant isn't capable of medical malpractice, the claim can't be for medical malpractice. So *Bryant*'s first step must remain; it isn't the problem.

Before 1975, only physicians, surgeons, and dentists could be held liable for medical malpractice. See *Kambas v St Joseph's Mercy Hosp of Detroit*, 389 Mich 249; 205 NW2d 431 (1973). But the Legislature, responding to *Kambas*, expanded the reach of medical-malpractice liability by amending the accrual statute to include other

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[7] See also *Bronson v Sisters of Mercy Health Corp*, 175 Mich App 647, 652-653 (1989) ("The providing of professional medical care and treatment by a hospital includes supervision of staff physicians and decisions regarding selection and retention of medical staff."); *Penner v Seaway Hospital*, 102 Mich App 697, 704-705 (1981) (holding that allegation that hospital breached its duty to require staff to comply with rules and law raised malpractice claim).

[8] See, e.g., *Trowell*, 316 Mich App at 686; *Lucas v Awaad*, 299 Mich App 345, 360; 830 NW2d 141 (2013); *Lee v Detroit Med Ctr*, 285 Mich App 51, 61; 775 NW2d 326 (2009).

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professionals. See *Adkins v Annapolis Hosp*, 420 Mich 87; 360 NW2d 150 (1984). As *Adkins* succinctly explained, "[a] malpractice action cannot accrue against someone who, or something that, is incapable of malpractice." *Id*. at 95.

In 1986, the Legislature enacted an accrual statute specifically for medical-malpractice actions. 1986 PA 178. Under the current accrual statute, a medical-malpractice claim can accrue against "a person or entity who is or who holds himself or herself out to be a licensed health care professional, licensed health facility or agency, or an employee or agent of a licensed health facility or agency who is engaging in or otherwise assisting in medical care and treatment, whether or not the licensed health care professional, licensed health facility or agency, or their employee or agent is engaged in the practice of the health profession in a sole proprietorship, partnership, professional corporation, or other business entity." MCL 600.5838a(1). The terms "licensed health facility or agency" and "licensed health care professional" are defined by reference to sections of the public health code. See MCL 600.5838a(1)(a), (b).

2. Step two: Did the alleged mistake occur within the course of the parties' professional relationship?

The next step is where *Bryant* started distinguishing the substance of medical-malpractice claims and ordinary-negligence claims. It held that courts must consider "whether the claim pertains to an action that occurred within the course of a professional relationship." 471 Mich at 422.

Bryant drew this step from *Dorris*. Both courts stated that, "'The key to a medical malpractice claim is whether it is alleged that the negligence occurred within the course

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of a professional relationship.'" *Bryant*, 471 Mich at 422, quoting *Dorris*, 460 Mich at 45.[9] And *Bryant* explained that the professional relationship must be one where a person or entity capable of malpractice was "subject to a contractual duty that required that professional, that facility, or the agents or employees of that facility,[10] to render professional health care services to the plaintiff." 471 Mich at 422-423.

Bryant and *Dorris* were right. Negligence occurring in the course of a professional relationship is "the key" for a malpractice claim. This is what distinguishes a medical-malpractice claim from every other claim against a medical provider. For example, if a doctor happens to have a car accident with a patient on his way home from work, the patient's claim against the doctor wouldn't pertain to an action that occurred within their professional relationship. So it wouldn't be a malpractice claim.

This part of *Bryant*'s test is also firmly rooted in Michigan law. It's traceable to this Court's decision in *Delahunt v Finton*, 244 Mich 226, 230; 221 NW 168 (1928),[11] which defined malpractice as "the negligent performance by a physician or surgeon[12] of the duties devolved and incumbent upon him on account of his contractual relations with his patient." *Id.* at 230. For decades, Michigan courts applied that definition. See *Becker*,

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[9] *Dorris* was, in turn, quoting *Bronson v Sisters of Mercy Health Corp*, 175 Mich App 647, 652-653; 438 NW2d 276 (1989), which cited *Becker v Meyer Rexall Drug Co*, 141 Mich App 481, 485; 367 NW2d 424 (1985), which relied on this Court's decision in *Delahunt v Finton*, 244 Mich 226, 230; 221 NW 168 (1928).

[10] These categories are taken from the accrual statute, MCL 600.5838a(1). See *Adkins*, 420 Mich at 94-95.

[11] *Dorris* quoted *Bronson*, 175 Mich App at 652-653, which cited *Becker*, 141 Mich App at 485, which relied on *Delahunt*.

[12] Again, the Legislature expanded medical-malpractice liability beyond physicians, surgeons, and dentists when it amended the accrual provision in 1975. *Adkins*, 420 Mich at 95.

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141 Mich App at 485 (holding that the plaintiff's claim was for malpractice under *Delahunt* because "[t]he duty allegedly breached … arose out of the professional relationship between defendant and decedent"); see also *Malik v Wm Beaumont Hosp*, 168 Mich App 159, 168; 423 NW2d 920 (1988) ("The term 'malpractice' denotes a breach of the duty owed by one rendering professional services to a person who has contracted for such services; in medical malpractice cases, the duty owed by the physician arises from the physician-patient relationship.").

But *Bryant* and *Dorris* tacked on another layer of analysis not found in *Delahunt*. Neither opinion explained why, or even acknowledge that it was deviating from precedent.

3. Step three: Is expert testimony required?

The third step is where *Bryant* went astray. It held that courts must consider "whether the claim raises questions of medical judgment beyond the realm of common knowledge and experience." 471 Mich at 422. In other words, "whether the claim raises questions of medical judgment requiring expert testimony …" *Id.* at 423. If the claim doesn't require expert testimony, it's an ordinary-negligence claim. *Id.*

There are three problems with *Bryant*'s adoption of the third step: (1) it's based on a misreading of Michigan case law, (2) it contradicts Michigan case law, and (3) it leads to the unworkable slippery slope illustrated in the Court of Appeals' opinion in this case.

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i. *Dorris* misread *Wilson* to require expert testimony in medical-malpractice cases. *Wilson* did no such thing.

Bryant relied on *Dorris* as support for the third step. And, true, *Dorris* stated that the distinction between medical malpractice and ordinary negligence "depends on whether the facts allegedly raise issues that are within the common knowledge and experience of the jury or, alternatively, raise questions involving medical judgment." 460 Mich at 46. *Dorris* cited *Wilson v Stilwill*, 411 Mich 587; 309 NW2d 898 (1981) for that proposition. But that's not what *Wilson* said.

In *Wilson*, the trial court directed a verdict for a hospital because the plaintiff didn't present expert testimony on the standard of care for his malpractice claim. This Court affirmed, holding that expert testimony was required because "the instant case presents a standard of conduct issue which cannot be determined by common knowledge and experience, but rather raises a question of medical judgment." *Id.* at 611.

There are two separate issues at play here. Whether a claim is for malpractice is one. Whether the claim requires expert testimony is the other. If the parties dispute what the standard of conduct required (and they usually do), expert testimony is required. *Id.* That's *Wilson*'s holding. But a claim can still be for malpractice if there's no dispute over the standard of care. *Wilson* confirmed that too. It stated that "when a medical malpractice action not involving ordinary negligence is brought against a hospital, **as a general rule, expert testimony is required**." *Id.* at 611 (emphasis added).

So *Wilson* acknowledged that, in "general," malpractice claims require expert testimony; but not always. *Dorris* misread *Wilson* to say that expert testimony is always

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required in medical-malpractice cases. *Bryant* mistakenly adopted that misreading as the third step of its analysis.

ii. *Bryant*'s adoption of *Dorris*'s misreading creates a conflict in Michigan case law. Malpractice claims don't always require expert testimony, yet *Bryant*'s test defines medical malpractice by the need for expert testimony.

Nearly every medical-malpractice case will require expert testimony. But, until *Dorris* and *Bryant*, this Court recognized that rare exceptions exist and not every malpractice claim requires expert testimony. See *Lince v Monson*, 363 Mich 135, 141; 108 NW2d 845 (1961) (malpractice case acknowledging that expert testimony isn't required "where the lack of professional care is so manifest that it would be within the common knowledge and experience of the ordinary layman that the conduct was careless and not conformable to the standards of professional practice and care employed in the community"); *Zanzon v Whittaker*, 310 Mich 340, 345; 17 NW2d 206 (1945) ("Both in this and in other jurisdictions authority will be found in support of the proposition that under certain circumstances, such as disclose to the mind of the layman failure to properly perform professional duty, **there may be recovery in malpractice cases notwithstanding no expert testimony is produced in support of plaintiff's claim**." (Emphasis added)); *Higdon v Carlebach*, 348 Mich 363, 374, 378; 83 NW2d 296 (1957) (no expert testimony required in malpractice against dentist who cut the plaintiff's tongue when only dispute was whether the plaintiff moved during a dental procedure); *Winchester v Chabut*, 321 Mich 114, 119; 32 NW2d 358 (1948) (no expert testimony required in malpractice action in which the defendant doctor left a cotton surgical

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sponge in the plaintiff's leg); *LeFaive v Asselin*, 262 Mich 443; 247 NW 911 (1933) (no expert testimony required for malpractice claim when surgeon left surgical needle in abdominal cavity); see also *Miles v Van Gelder*, 1 Mich App 522, 533; 137 NW2d 292 (1965) (discussing "the law concerning the exception to the general rule requiring expert evidence in an action of malpractice").[13]

This Court's opinion in *LeFaive* illustrates the point. The plaintiff alleged that the defendant left a curved surgical needle in his abdomen during an appendectomy. After a jury verdict for the plaintiff, the defendant argued that "in malpractice cases [expert] evidence is necessary to establish negligence." 262 Mich at 445-446. This Court disagreed and affirmed the jury's verdict. *LeFaive* explained that "[i]n the majority of such [malpractice] cases, the professional standard of practice is necessarily involved and requires testimony of competent experts." *Id.* at 446. But expert testimony wasn't required for the plaintiff's malpractice claim because "there is no question of skill or judgment, no question of practice beyond the knowledge of laymen." *Id.*

Though *LeFaive* is expressly a malpractice case, it wouldn't be under *Bryant*. So the third step in *Bryant*'s test creates a conflict in Michigan law.

On one hand, there's an undisturbed line of case acknowledging that expert testimony is usually, but not always, required in medical-malpractice cases. Indeed, this Court reiterated that point last year. See *Elher v Misra*, 499 Mich 11, 21; 878 NW2d 790

[13] There are some errant Court of Appeals cases stating that expert testimony is an "absolute prerequisite" to recovering on a malpractice claim. See, e.g., *Bivins v Detroit Osteopathic Hosp*, 77 Mich App 478, 488; 258 NW2d 527 (1977), rev'd on other grounds 403 Mich 820; 282 NW2d 926 (1978).

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(2016) ("'**Generally**, expert testimony is required in a malpractice case in order to establish the applicable standard of care and to demonstrate that the professional breached that standard.'"), quoting *Sullivan v Russell*, 417 Mich 398; 338 NW2d 181 (1983) (holding that the plaintiff "made out a prima facie case of dental malpractice" because expert testimony wasn't required given the nature of the claim—"unsolicited treatment of teeth … which resulted in pain and a change in appearance"). On the other hand, there's *Bryant* and *Dorris*, holding that the need for expert testimony defines a malpractice case.

The conflict is irreconcilable. Under *Bryant*, when expert testimony isn't required, the claim isn't for medical malpractice. 471 Mich at 423. But *Elher* and nearly a century of case law preceding it leaves the door open for malpractice claims that don't require expert testimony. *Elher* has stronger footing in Michigan law. And *Bryant* didn't suggest that it was overruling anything, much less decades of precedent.[14]

iii. Bryant's slippery slope and the problems that it causes.

The Court of Appeals' opinion in this case is a predictable result of *Bryant*'s third step. The analysis decays. It becomes a question of how superficial or simplistic the alleged error can be made to sound. Courts are left asking questions like whether the medical provider answered a cell phone when assisting a patient. It encourages artfully

[14] It's unlikely that the *Bryant* majority intended to silently overrule nearly a century of case law. The same Justices were critical of the Court's history of "displac[ing] without overruling" its precedent, which resulted in "a confused jumble" of case law in other areas of the law. See *Rory v Continental Ins Co*, 473 Mich 457, 488; 703 NW2d 23 (2005); *Wilkie v Auto-Owners Ins Co*, 469 Mich 41, 60; 664 NW2d 776 (2003).

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vague pleading. And Michigan jurisprudence and the parties operating under it suffer as a result.

Identifying the nature of the action from the outset of litigation has heightened importance for medical-malpractice claims. Tort reform created specific procedural requirements for medical-malpractice claims. And failure to follow those requirements carries significant consequences.

Plaintiffs must serve a notice of intent to sue, wait a specified period of time, and file affidavits of merit with their complaints. MCL 600.2912b; MCL 600.2912d. Defendants are required to respond with affidavits of meritorious defense. MCL 600.2912e. Both affidavits must be signed by health professionals who meet specific statutory requirements. MCL 600.2169.

Failure to comply with those procedures can lead to a statute of limitations defense that would resolve the case early on or it could result in a default against the defendant. See *Tyra v Organ Procurement Agency of Mich*, 498 Mich 68; 869 NW2d 213 (2015) (premature filing of complaint without waiting notice of intent period doesn't commence the action and limitation period continues to run); *Scarsella v Pollak*, 461 Mich 547; 607 NW2d 711 (2000) (complaint filed without affidavit of merit doesn't toll limitation period for malpractice claim); *Kowalski v Fiutowski*, 247 Mich App 156; 635 NW2d 502 (2001) (defendant could be defaulted for failure to file affidavit of meritorious defense).

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Aside from the procedural requirements, the distinction between medical malpractice and ordinary negligence can also significantly change the stakes. And knowing the stakes is prerequisite to settlement.

Whether a claim is for medical-malpractice can effect whether joint liability applies. MCL 600.6304(6). Medical malpractice actions are also subject to specific rules on how to calculate a judgment. MCL 600.6306a. And, perhaps most significant, medical-malpractice actions are subject to noneconomic damages caps. MCL 600.1483. There's no cap if the plaintiff only alleges an ordinary-negligence claim. So the type of claim that's at issue can drastically change the stakes. See, e.g., *Jenkins v Patel*, 471 Mich 158; 684 NW2d 346 (2004) (holding that damages cap applied to $10 million jury award).

Here, for example, Trowell's complaint seeks $2.5 million in noneconomic damages. *Trowell*, 316 Mich App at 684. The cap would tame that demand early on. Settlement is at best unlikely and probably impossible when the parties don't know which proverbial ballpark they are in. And, of course, "[p]ublic and judicial policies favor settlement." *Watts v Mich Dept of State,* 394 Mich 350, 356; 231 NW2d 43 (1975) (citation omitted); *Stefanac v Cranbrook Educ Comm'y*, 435 Mich 155, 163; 458 NW2d 56 (1990) ("[T]he law favors settlements.").

The Court of Appeals opinion in this case suggests a useful illustration of the problem. The panel suggested that Trowell's claim would be for ordinary negligence "if evidence was developed showing that the aide dropped her because the aide decided to answer a cell phone call …" *Trowell*, 316 Mich App at 700. But what if, for example,

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Trowell testifies that the nurse's aide dropped her because the aide answered her cell phone and the nurse's aide testifies that she didn't answer her cell phone? That would be a credibility issue. Only a jury could resolve it. So, under *Bryant*'s third step, the entire nature of the case would be unknown until the jury returns its verdict. Whether a notice of intent, affidavit of merit, and affidavit of meritorious defenses were required and whether the noneconomic damages cap applied couldn't be known until the end of a trial. In other words, the parties would have no idea what the rules were until the end of the game. That's unworkable and unfair.

It's particularly unfair because it's avoidable. Other malpractice actions don't suffer from the same problem. The analysis for distinguishing malpractice is simpler in those cases. They aren't subject to and don't get tripped up in *Bryant*'s third step. Instead, courts look to "[t]he type of interest allegedly harmed …" *Aldred v O'Hara-Bruce,* 184 Mich App 488, 490-491; 458 NW2d 671 (1990), citing *Barnard v Dilley*, 134 Mich App 375, 378; 350 NW2d 887 (1984) and *Stroud v Ward*, 169 Mich App 1, 9; 425 NW2d 490 (1988). If the claim involves a professional's alleged negligent performance of duties he owed the plaintiff based on a contractual relationship, it's a malpractice claim. *Delahunt*, 244 Mich at 230. So, for example, when a claim against an attorney is based on "inadequate representation," it's a malpractice claim, regardless whether the alleged error was obvious or nuanced. *Aldred,* 184 Mich App at 490-491.

As the parties' briefs illustrate, the Court of Appeals has struggled to consistently assess the vagaries inherent in attempting to parse what does and doesn't require medical judgment beyond a layman's knowledge, particularly in patient-fall cases.

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Compare Plaintiff-Appellee Answer pp. 20-21, 26-27, citing *Sheridan v West Bloomfield Nursing & Convalescent Ctr, Inc*, unpublished opinion per curiam of the Court of Appeals, issued Mar 6, 2007 (Docket No. 272205); 2007 WL 678642; *Sawicki v Katzvinsky*, unpublished opinion per curiam of the Court of Appeals, issued Mar 17, 2015 (Docket No. 318818); 2015 WL 1214843; *McIver v St John Macomb Oakland Hosp*, unpublished opinion per curiam of the Court of Appeals, issued Feb. 12, 2015 (Docket No. 303090); 2015 WL 630393, with *Wiley*, 257 Mich App at 510, *Groesbeck*, unpub op, 2013 WL 951090 (Ex. 1); *Campins*, unpub op, 2004 WL 2009264 (Ex. 2); *Lewandowski*, unpub op, 2003 WL 22850024 (Ex. 3).

There's nothing unique to medical-malpractice claims that requires a more involved analysis that could, potentially, leave the parties in the dark about the nature of the claim and the available damages until the very end of the case.

C. Solutions to the problem.

Identifying a problem isn't much use without a solution. West Branch Regional suggests two potential solutions.

1. Proposed Solution 1: Eliminate the third part of *Bryant*'s analysis.

The simplest solution is often the best. And, here, the simplest solution is to eliminate the third step. The result is that a claim is for medical malpractice if (1) the defendant is capable of medical malpractice and (2) the claim pertains to an action that occurred within the course of a professional relationship. It's a return to *Delahunt*,

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which neither *Bryant* nor *Dorris* gave any reason for departing from. It's a return to the same analysis that applies for all other types of malpractice claims.

The third step in *Bryant*'s analysis had no basis in Michigan law. *Bryant* adopted it from *Dorris* and *Dorris* misread *Wilson* to create it. There is no reason to perpetuate that error. In fact, Michigan law will benefit from eliminating it. The third step conflicts with a long-line of this Court's cases and eliminating it resolves that conflict.

The concern with eliminating the third step might be that the resulting test is too broad. But the concern is unfounded. The second step sifts out those claims that are untethered to medical treatment, e.g., a car accident between doctor and patient.

Another example: parties might dispute whether a claim is for medical malpractice if the plaintiff trips over loose carpeting in his doctor's office. One party might argue that it's a premises-liability claim while the other says that it's medical malpractice. Premises liability is the better argument. See *Buhalis*, 296 Mich App at 692 ("If the plaintiff's injury arose from an allegedly dangerous condition on the land, the action sounds in premises liability …."). But, most important, the distinction wouldn't hinge on factual questions. It's a question of law in which "the gravamen of an action is determined by reading the complaint as a whole …." *Id.* at 691 (citation omitted). The parties will know the ground rules before the jury returns a verdict.

The point isn't that parties will never disagree about the nature of the action. They most certainly will sometimes. The point is that parties should be able to get an answer before they submit the case to a jury. *Bryant*'s third step, as predictably interpreted by the Court of Appeals in this case, creates a situation in which that may

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not happen. Eliminating *Bryant*'s third step would put medical-malpractice law in line with other cases. It would allow courts to determine the nature of the claim from reading the complaint as a whole instead of pondering the possible proofs and what does and doesn't implicate "medical judgment."

So how would this test apply in this case? In a word, easily. The hospital is capable of malpractice. And the alleged errors pertain to an action that occurred within the course of Trowell's professional relationship with the hospital. Neither point was disputed. *Trowell*, 316 Mich App at 687 n.3, 692 n.5. So Trowell's claims are for malpractice only.

How would this test have applied in *Bryant*? Again, easily. *Bryant* lumped its first and second steps together. 471 Mich at 425. The defendant was capable of malpractice and each of the plaintiff's claims involved her decedent's professional relationship with the defendant. *Id.* So all of the claims were for medical malpractice.

The only claim in *Bryant* that would have been affected by eliminating the third step was the last one, which the Court labeled "failure to take steps." *Id.* at 430. The plaintiff alleged that nurses and nurse assistants failed to take corrective measures after they determined that her decedent was at risk of asphyxiation. *Id.* at 430. *Bryant* held that the claim was for ordinary negligence because no expert testimony was required to determine whether the defendant was negligent in failing to respond to the risk of asphyxiation. *Id.* at 431.

Bryant tried to make a distinction when there was no difference. The alleged failure to take corrective action involves an obvious error. But it's an error in providing

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professional care, much like leaving a surgical needle in a patient's abdomen. *LeFaive*, 262 Mich 443. It was and should be a medical-malpractice claim.

2. Proposed Solution 2: Amend the third part of *Bryant*'s test based on the description of a medical-malpractice claim in the accrual statute.

Alternatively, this Court might amend *Bryant*'s third step to add some refinement while eliminating the conflict with other cases. A safe way to do that is to look to the Legislature's description of a malpractice claim in the accrual statute, MCL 600.5838a:

> [A] claim based on the medical malpractice of a person or entity who is or who holds himself or herself out to be a licensed health care professional, licensed health facility or agency, or an employee or agent of a licensed health facility or agency **who is engaging in or otherwise assisting in medical care and treatment**, whether or not the licensed health care professional, licensed health facility or agency, or their employee or agent is engaged in the practice of the health profession in a sole proprietorship, partnership, professional corporation, or other business entity, accrues at the time of the act or omission that is the basis for the claim of medical malpractice, regardless of the time the plaintiff discovers or otherwise has knowledge of the claim. [MCL 600.5838a(1) (emphasis added).]

The bolded language can be used for an effective third step. Under this alternative approach, courts would ask whether (1) the defendant is capable of medical malpractice, (2) the claim pertains to an action that occurred within the course of a professional relationship, and (3) the defendant was engaging in or otherwise assisting in medical care and treatment when the act or omission that is the basis for the claim

occurred. If all three questions are answered in the affirmative, the claim is for medical malpractice.

This Court relied on the "engaging or otherwise assisting" language when distinguishing medical malpractice from ordinary negligence in *Regalski*, 459 Mich 891. Recall that the plaintiff's decedent was injured when a technician moved her from her wheelchair onto an examination table for a cardiac test. This Court held that the claim was for medical malpractice because "the technician was 'engaging in or otherwise assisting in medical care and treatment' in the performance of the act that is the basis of the lawsuit …." *Id.*, quoting MCL 600.5838a(1).

Bryant chose not to rely on the accrual statute, stating that "it does not define what constitutes a medical malpractice action." *Id.* at 421. That's true. The statute doesn't expressly define the term "medical malpractice." It doesn't say, "Medical malpractice means …."

But the language in the accrual statute is still a legislative description of the type of claim that is accruing. In other words, the Legislature indicated that a claim is for medical malpractice if the defendant was "engaging in or otherwise assisting in medical care and treatment" when performing the act that is the basis of the lawsuit. The Legislature expanded the reach of medical-malpractice liability when it enacted the accrual statute. See *Adkins*, 420 Mich at 94-95. In doing so, it gave more professionals and entities the protections of tort reform. There's no reason that its description of the type of activity involved in medical-malpractice claims—"engaging in or otherwise assisting in medical care and treatment"—should be given any less weight.

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So how would this test apply in this case? *Regalski* concluded that moving a patient from a wheelchair to an examination table was "engaging in or otherwise assisting in medical care and treatment." Likewise, a nurse's aide who moves a hospital patient from her bed to the bathroom is engaging in or otherwise assisting in medical care and treatment. The patient can't be left to soil and then fester in her bed sheets. That, obviously, isn't conducive to any sort of medical care or treatment.

How would this test apply in *Bryant*? All of the alleged errors would have been medical-malpractice claims, including the alleged "failure to take steps." The nurses who allegedly didn't take corrective measures when the patient was a known risk of asphyxiation were "engaging in or otherwise assisting in medical care and treatment." It was an error of omission, but medical malpractice claims include alleged "act[s] and omission[s]." MCL 600.5838a(1). So, under this alternative test, the failure-to-take-steps claim is a medical-malpractice claim.

The Achilles heel to this alternative is the undefined phrase "medical care and treatment." But defining that term is a question of law that courts can resolve. It doesn't (or shouldn't) turn on factual issues that can't be resolved short of trial. And it doesn't lead to a conflict with other case law. As a result, it would be an improvement over *Bryant*'s third step.

Bryant's third step attempted to add some refinement to the analysis. Though the refinement that it chose went too far, this Court might want to retain some refinement. Tracking the language in the accrual statute can safely do that without creating a

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conflict in the law. It won't be as clean or as faithful to this Court's precedent (*Delahunt*) as simply eliminating the third step though.

Relief Requested

Altering *Bryant*'s test for identifying medical-malpractice claims is a jurisprudentially significant issue. This Court ordered supplemental briefing and argument on "whether to grant the application or take other action." If this Court is going to revisit *Bryant* (and it should), this Court should grant Providence Hospital's application and invite *amicus* participation.

But even if *Bryant* is left intact (either with or without a leave grant), the Court of Appeals' opinion in this case cannot survive. It's wrong. It encourages gamesmanship and vague complaints. It undermines the effect of the pre-suit notice and affidavit-of-merit procedures that the Legislature adopted. And it will inhibit settlements in would-be malpractice cases. This Court should ultimately reverse and hold that Trowell's claim is for medical malpractice only.

Collins Einhorn Farrell PC

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Dated: July 28, 2017

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EXHIBIT 1

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2013 WL 951090
Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

UNPUBLISHED
Court of Appeals of Michigan.

Harvey GROESBECK, guardian of Loretta Groesbeck, a protected person,, Plaintiff–Appellee,
v.
HENRY FORD HEALTH SYSTEM, d/b/a Henry Ford Bi–County Hospital, d/b/a Henry Ford Macomb Hospital, d/b/a Detroit Osteopathic Hospital, Defendant–Appellant.

Docket No. 307069.
|
Feb. 26, 2013.

Macomb Circuit Court; LC No.2009–003523–NO.

Before: HOEKSTRA, P.J., and K.F. KELLY and BECKERING, JJ.

Opinion

PER CURIAM.

***1** Defendant appeals by leave granted from an order denying its motion for partial summary disposition. The trial court held that plaintiff could pursue a claim based on ordinary negligence rather than medical malpractice and that the finder of fact could decide the case based upon a theory of res ipsa loquitur. We reverse.

I. BASIC FACTS

Plaintiff sued defendant for injuries suffered by 86–year–old Loretta Groesbeck when she fell while undergoing rehabilitation treatment in defendant's hospital on February 1, 2007. On the day in question Loretta was being treated by Esther Karunakar, a licensed physical therapist. Loretta had suffered a minor stroke and Karunakar was to evaluate Loretta's condition and determine the appropriate course of physical therapy to help her stand and walk. Karunakar first saw Loretta on the morning of February 1, 2007. At that first meeting Loretta was too dizzy to undergo the physical therapy evaluation. Karunakar returned to visit Loretta later that afternoon. Loretta felt improved, so Karunakar proceeded with the evaluation. Karunakar assessed Loretta's mobility by having her stand, move to a wheelchair, then operate the wheelchair to move down a hallway. Finally Karunakar assessed Loretta's gait by having her stand up and walk a few steps with the assistance of a gait belt [1] and pyramid walker. Loretta began walking with the assistance of the walker. Karunakar followed behind Loretta, holding the gait belt with one hand and the wheelchair with the other. After taking three steps Loretta collapsed and fell, striking her head.

1 The gait belt goes around the patient's waist and is held by the therapist, who is ready to provide support if necessary.

Plaintiff filed his complaint against defendant on July 1, 2009. Plaintiff's complaint was preceded by a Notice of Intent. Count I of plaintiff's complaint alleged a claim for ordinary negligence, asserting that defendant's employees failed to exercise reasonable care and caution in connection with the physical therapy session by allowing Loretta to stand and walk and by failing to secure or hold her to prevent her from falling while she attempted to walk. Count II of plaintiff's complaint raised an alternative claim of medical malpractice based on the same alleged negligence. Count IV of the complaint asserted a claim for negligence based on a theory of res ipsa loquitur, alleging that Loretta's injury was of a kind which does not ordinarily occur without negligence, that defendant had exclusive control over Loretta and the surrounding area, and that any possible explanation as to why she was allowed to fall would be accessible to defendant rather than to plaintiff.

Plaintiff's complaint was accompanied by affidavits of merit signed by physical therapist expert Leonard Elbaum, who opined that Karunakar breached the standard of care for physical therapists by not adequately evaluating her patient's condition and by failing to properly secure or hold Loretta to prevent her from falling while attempting to walk. Elbaum reiterated this opinion in his deposition testimony, maintaining that Karunakar's actions in evaluating Loretta fell below the standard of care applicable to licensed physical therapists by failing to recognize that her patient was at great risk for falling and that Karunakar violated the standard

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of care by failing to adequately guard Loretta against falling. Plaintiff's second physical therapy expert, Paul Roubal, believed that Karunakar committed an error in professional judgment by immediately starting gait evaluation or training for Loretta following an initial evaluation which showed that she suffered from poor standing balance. At deposition Dr. Elbaum admitted that falls can occur in the course of physical therapy during gait training or assessment even where the physical therapist has not violated the standard of care. Elbaum testified that the fact that a patient fell did not mean that the physical therapist violated the standard of care and that "[i]t's possible you can do the very best you can and still have someone injure themselves during a fall...."

***2** Defendant moved for partial summary disposition pursuant to MCR 2 .116(C)(8) and (10), asking the court to dismiss plaintiff's claim for ordinary negligence and claim for negligence brought under the theory of res ipsa loquitur. Defendant argued that there was no genuine issue of material fact that plaintiff's negligence claims called into question the professional standards for physical therapists and the decision-making of physical therapist Esther Karunakar. Defendant maintained that when and whether to have an impaired patient try to walk was a matter of medical judgment to be exercised by the professional therapist. Defendant argued that the applicable standards and their application were well beyond the understanding of ordinary laymen and, accordingly, the claim was one for medical malpractice rather than ordinary negligence.

In response, plaintiff's counsel characterized the matter as one of common knowledge or common sense rather than involving trained or professional judgment, arguing "How medically trained do you have to be to know that you're not supposed to let her fall; that you have to hold her?" and that one did not have to be an expert to know that "if you're holding a patient in your arms, you can't drop her." Plaintiff argued that a jury could easily understand the theory of negligence involved without expert testimony.

In denying defendant's motion, the trial court cited this Court's unpublished opinion in *Sheridan v. West Bloomfield Nursing Ctr,* unpublished opinion per curiam of the Court of Appeals, issued March 6, 2007 (Docket No. 272205). The trial court concluded that plaintiff's claim was within the common knowledge and experience of an ordinary juror and did not require expert testimony concerning the exercise of medical judgment:

> This Court is convinced that, as an ordinary person would be, that as a matter of common sense, that if you are helping a five-foot-two-inch, one-hundred four-pound, eighty-six-year-old woman, experiencing dizzy spells and dizziness, and you're helping her to walk, you should hold on carefully or get further assistance. Such is the matter clearly within the realm of common knowledge and experience when dealing with persons in such a condition.

The trial court also denied summary disposition of plaintiff's res ipsa loquitur theory, explaining as follows:

> The elements, as we've just gone over res ipsa loquitur are that it doesn't usually absent someone's negligence; that it's caused by agency within the defendant's control; that it's not due to the plaintiff's actions; and, four, evidence of true—of the true explanation of the event must be more readily accessible to the defendant than to the plaintiff.
>
> The injury in this case did not result from a medical procedure. It is not contested that it resulted from a fall. The fall came as the therapist was helping plaintiff up or helping her to walk or asking her to walk, but in some way directing her and controlling her. The plaintiff's statement was that she was quote/unquote "dropped". Whether dropped or fell, it is within the ordinary sense and common knowledge that an elderly person who is suffering continuous dizziness needs full assistance to get up and to ambulate. The injury in this case would not ordinarily occur in such a circumstance, but for some negligence. This issue can be determined by a jury without expert testimony.

***3** The trial court denied defendant's motion in an order issued September 27, 2011, and subsequently denied defendant's motion for reconsideration. On December 15, 2011, this Court granted defendant's application for leave to appeal, but denied its motion for peremptory reversal. *Groesbeck v. Henry Ford Health Sys,* unpublished order of the Court of Appeals, entered December 15, 2011 (Docket No. 307069). [2]

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2 The Michigan Supreme Court denied defendant's application for leave to appeal from this Court's order. *Groesbeck v. Henry Ford Health Sys.,* 491 Mich. 855, 809 N.W.2d 147 (2012).

II. STANDARDS OF REVIEW

This Court reviews de novo a trial court's decision on a motion for summary disposition. *Maiden v. Rozwood,* 461 Mich. 109, 118, 597 N.W.2d 817 (1999). Summary disposition pursuant to MCR 2.116(C)(8) is appropriate where "[t]he opposing party has failed to state a claim on which relief can be granted." Therefore, a motion for summary disposition under MCR 2.116(C)(8) tests the legal sufficiency of a complaint. *Beaudrie v. Henderson,* 465 Mich. 124, 129, 631 N.W.2d 308 (2001). "The motion should be granted if no factual development could possibly justify recovery." *Id.* In contrast, a motion under MCR 2.116(C)(10) tests the factual sufficiency of a complaint. *Maiden,* 461 Mich. at 120, 597 N.W.2d 817. A reviewing court must consider the affidavits, depositions, admissions, and other documentary evidence submitted by the parties and, viewing that evidence in the light most favorable to the nonmoving party, determine whether there is a genuine issue of material fact for trial. *Id.*

This Court also reviews de novo the proper classification of an action as ordinary negligence or medical malpractice. *Bryant v. Oakpointe Villa Nursing Ctr,* 471 Mich. 411, 419, 684 N.W.2d 864 (2004).

Similarly, this Court reviews de novo whether the doctrine of res ipsa loquitur applies to a particular case. *Jones v. Porretta,* 428 Mich. 132, 154 n. 8, 405 N.W.2d 863 (1987).

III. ORDINARY NEGLIGENCE VS. MEDICAL MALPRACTICE

Defendant argues that the trial court erred in failing to grant defendant summary disposition on plaintiff's ordinary negligence claim where plaintiff's action was one that clearly involved the exercise of medical judgment. We agree.

Not all injuries that occur in a medical facility at the hands of health care providers sound in medical malpractice. *Bryant,* 471 Mich. at 421, 684 N.W.2d 864. Some injuries are the result of "ordinary negligence," where no medical judgment is exercised. Our Supreme Court has explained how to distinguish a medical malpractice claim from one alleging ordinary negligence:

> A medical malpractice claim is distinguished by two defining characteristics. First, medical malpractice can occur only " 'within the course of a professional relationship.' " Second, claims of medical malpractice necessarily "raise questions involving medical judgment." Claims of ordinary negligence, by contrast, "raise issues that are within the common knowledge and experience of the [fact-finder]." Therefore, a court must ask two fundamental questions in determining whether a claim sounds in ordinary negligence or medical malpractice: (1) whether the claim pertains to an action that occurred within the course of a professional relationship; and (2) whether the claim raises questions of medical judgment beyond the realm of common knowledge and experience. If both these questions are answered in the affirmative, the action is subject to the procedural and substantive requirements that govern medical malpractice actions. [*Id.* at 422, 684 N.W.2d 864 (citations omitted).]

***4** There is no dispute that Loretta's injury occurred within the course of a professional relationship. The only issue is whether "the reasonableness of the health care professionals' action can be evaluated by lay jurors, on the basis of their common knowledge and experience, it is ordinary negligence" or whether "the reasonableness of the action can be evaluated by a jury only after having been presented the standards of care pertaining to the medical issue before the jury explained by experts." *Id.* at 423, 684 N.W.2d 864.

In *Bryant,* the plaintiff's decedent was a resident in a nursing home and suffered a myriad of physical ailments. *Id.* at 415, 684 N.W.2d 864. Staff were authorized to employ "various physical restraints" including wedges or bumper pads preventing the decedent from "entangling herself in ... the rails" of her bed. *Id.* at 415–416, 684 N.W.2d 864. Nursing assistants observed that the decedent "was lying in her bed very close to the bed rails and was tangled in her restraining vest, gown, and bed sheets." *Id.* at 416, 684 N.W.2d 864. They untangled her and informed their supervisor that the wedges afforded inadequate protection. *Id.* The following day, the decedent "slipped between the rails of her bed and was in large part out of the bed with the lower half of her body on the floor

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but her head and neck under the bed side rail and her neck wedged in the gap between the rail and the mattress, thus preventing her from breathing" and she died as a result of positional asphyxiation. *Id.* at 417, 684 N.W.2d 864.

The plaintiff's complaint in *Bryant* alleged that the defendant negligently failed to train staff to properly assess the risk of positional asphyxia, failed to inspect the beds and bed frames to ensure that there was no risk of positional asphyxia, and failed to take steps to protect plaintiff's decedent when she was, in fact, discovered entangled between the bed rails and the mattress the day before her death. *Id.* at 417–418, 684 N.W.2d 864. Our Supreme Court held that the plaintiff's failure to train and failure to inspect claims sounded in medical malpractice. With respect to the plaintiff's claim for failure to adequately train, the *Bryant* Court noted:

> in order to assess the risk of positional asphyxiation posed by bed railings, specialized knowledge is generally required, as was notably shown by the deposition testimony of plaintiff's own expert, Dr. Steven Miles. Dr. Miles testified that hospitals may employ a number of different bed rails depending on the needs of a particular patient. Accordingly, the assessment of whether a bed rail creates a risk of entrapment for a patient requires knowledge of that patient's medical history and behavior. It is this particularized knowledge, according to Dr. Miles, that should prompt a treating facility to use the bedding arrangement that best suits a patient's "individualized treatment plan," and to properly train its employees to recognize any risks inherent in that bedding arrangement and to adequately monitor patients to minimize those risks. [*Id.* at 427, 684 N.W.2d 864 (footnotes omitted).]

***5** Similarly, with respect to the plaintiff's failure to inspect claim, the *Bryant* Court noted:

> as demonstrated through the deposition testimony of plaintiff's expert, the risk of asphyxiation posed by a bedding arrangement varies from patient to patient. The restraining mechanisms appropriate for a given patient depend upon that patient's medical history. Thus, restraints such as bed railings are, in the terminology of plaintiff's expert physician, part of a patient's "individualized treatment plan."
>
> The risk assessment at issue in this claim, in our judgment, is beyond the ken of common knowledge, because such an assessment require[s] understanding and consideration of the risks and benefits of using and maintaining a particular set of restraints in light of a patient's medical history and treatment goals. In order to determine then whether defendant has been negligent in assessing the risk posed by Hunt's bedding arrangement, the fact-finder must rely on expert testimony. [*Id.* at 429–430, 684 N.W.2d 864.]

However, the Supreme Court concluded that the plaintiff's claim for failure to take steps to protect the decedent after previously discovering her tangled in her bed sounded in ordinary negligence:

> No expert testimony is necessary to determine whether defendant's employees should have taken *some* sort of corrective action to prevent future harm after learning of the hazard. The fact-finder can rely on common knowledge and experience in determining whether defendant ought to have made an attempt to reduce a known risk of imminent harm to one of its charges. [*Id.* at 430–431, 684 N.W.2d 864 (emphasis in original).]

In denying defendant's motion for summary disposition, the trial court relied on *Bryant* and an unpublished case —*Sheridan v. West Bloomfield Nursing & Convalescent Ctr.*[3] In *Sheridan,* the plaintiff's complaint alleged that the defendants were negligent when "two nurse assistants dropped plaintiff's decedent while moving her from her bed to a wheelchair using a 'gait belt.' " *Id.* at slip op p. 1. The trial court in *Sheridan* granted the defendants' motion for summary disposition after concluding that the plaintiff's claim sounded in medical malpractice. *Id.* This

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Court reversed, finding that the issue of "whether, having decided to use and having secured the gait belt, defendants acted reasonably when they failed to maintain a secure grip on plaintiff's decedent and dropped her or allowed her to fall on the floor" was a matter "within the common knowledge and experience of an ordinary juror and [did] not require expert testimony concerning the exercise of medical judgment." *Id.* However, critical to the case at bar, is the following distinction—the plaintiff in *Sheridan* "is not challenging the decision to move the decedent from her bed, the decision to use a gait belt, or the manner in which the gait belt was fastened to her body." Here, plaintiff hastily notes in his appellate brief that the "crux of this lawsuit" is that Karunakar "failed to carefully hold Ms. Groesbeck to prevent her from falling ." However, a clear reading of the complaint belies that notion. Plaintiff plainly takes issue with Karunakar's decision to conduct the gait assessment in the first place.

3 An unpublished opinion "has no precedential force." *Nuculovic v. Hill,* 287 Mich.App. 58, 68, 783 N.W.2d 124 (2010); MCR 7.215(C)(1).

***6** For its part, defendant relies upon *Sturgis Bank & Trust Co. v. Hillsdale Community Health Ctr.,* 268 Mich.App. 484, 708 N.W.2d 453 (2005). In *Sturgis,* the plaintiff was injured when she fell out of her hospital bed. *Id.* at 486, 708 N.W.2d 453. "Plaintiff alleged in the complaint that defendant's nursing staff was negligent in failing to prevent [her] from falling out of her hospital bed, which could have been accomplished by proper monitoring and the use of bedrails, where hospital personnel were aware that [she] was in a physical and mental state that required heightened scrutiny in guarding against such an accident." *Id.* at 486–487, 708 N.W.2d 453. The trial court found that the plaintiff's claim sounded in medical malpractice and this Court agreed:

> It is clear from the deposition testimony that a nursing background and nursing experience are at least somewhat necessary to render a risk assessment and to make a determination regarding which safety or monitoring precautions to utilize when faced with a patient who is at risk of falling. While, at first glance, one might believe that medical judgment beyond the realm of common knowledge and experience is not necessary when considering [the plaintiff's] troubled physical and mental state, the question becomes entangled in issues concerning [the plaintiff's] medications, the nature and seriousness of the closed-head injury, the degree of disorientation, and the various methods at a nurse's disposal in confronting a situation where a patient is at risk of falling. The deposition testimony indicates that there are numerous ways in which to address the risk, including the use of bedrails, bed alarms, and restraints, all of which entail some degree of nursing or medical knowledge. Even in regard to bedrails, the evidence reflects that hospital bedrails are not quite as simple as bedrails one might find at home. In sum, we find that, although some matters within the ordinary negligence count might arguably be within the knowledge of a layperson, medical judgment beyond the realm of common knowledge and experience would ultimately serve a role in resolving the allegations contained in this complaint. [*Id.* at 498, 708 N.W.2d 453.]

In *David v. Sternberg,* 272 Mich.App. 377, 726 N.W.2d 89 (2006), the plaintiff suffered injury to her foot following a bunionectomy. She alleged that "defendants failed to properly apply strictures to the leg, ankle, and foot, failed to take steps to relieve pain and loss of circulation, failed to properly train their staffs, failed to respond to plaintiff's complaint of pain, and failed to clean and change the dressing." *Id.* at 383, 726 N.W.2d 89. The trial court determined that the plaintiff's claim sounded in medical malpractice and the plaintiff appealed, arguing that "her claim is not about how the bandage was wrapped, but about defendants' failure to take corrective action despite plaintiff's complaints of pain and fever." *Id.* She cited the deposition testimony of her expert, who testified that "it is within the common knowledge of a layperson that these types of complaints indicate a cutoff in blood supply and

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require removal of the bandage." *Id.* This Court found that, regardless of how the plaintiff attempted to couch her claims, her claims sounded in medical malpractice because they raised questions of medical judgment:

> ***7** According to defendant Charlanne Bratton's deposition testimony, plaintiff underwent surgery on her foot on February 15, 2002. On February 18, 2002, Dr. Bratton removed the outer layers of the surgical dressing and decided not to reapply certain parts of the dressing. On February 22, 2002, Dr. Bratton removed all the layers of the dressing and reapplied some layers more loosely. X-rays were also taken and read at this time. Dr. Bratton assessed plaintiff's condition and determined there was no infection or abnormal microbial growth. On February 25, 2002, Dr. Bratton removed all the dressing and reapplied some layers. At each of these visits, Dr. Bratton determined that there was appropriate capillary fill in the toes and no signs of infection. In all these visits, Dr. Bratton exercised medical judgment in evaluating plaintiff's condition and deciding how to treat her. On the basis of plaintiff's complaint and the record evidence, we conclude that discerning infection, capillary flow, and the postsurgical condition of plaintiff's surgical site and identifying and treating plaintiff's medical condition are not within the realm of common knowledge....This is different from the *Bryant* case, in which the action the defendant failed to take was simply untangling the plaintiff from bedsheets. Because plaintiff's allegations in this case raise questions involving medical judgment, her claim sounds in medical malpractice, not ordinary negligence. [*Id.* at 384, 726 N.W.2d 89.]

Here, just as in *Sturgis* and *David,* plaintiff's claims raise questions involving the medical or professional judgment. There are two issues at play: 1) whether Karunakar adequately assessed Loretta's physical abilities before testing her ability to walk; and, 2) whether Karunakar took adequate or reasonable precautions to prevent Loretta from falling during the assessment. While an ordinary layman may know that an elderly patient with impaired balance may fall, he is not likely to know when it is proper to assess that person's gait or what precautions to take to limit the risk of falling. It takes medical knowledge and judgment beyond the realm of common knowledge and experience to determine whether the assessment should have been performed and what precautions should have been taken to prevent Loretta from falling under the circumstances presented. One need only look to plaintiff's complaint and the testimony of her experts to see that the action clearly sounds in medical malpractice.

The ordinary negligence claim in plaintiff's complaint provided, in relevant part:

> a. Negligently allowed LORETTA GROESBECK to ambulate or walk, which a reasonably careful person would not do where LORETTA GROESBECK required two-person assisted showers;
>
> b. Negligently allowed LORETTA GROESBECK to ambulate or walk, which a reasonably careful person would not do where LORETTA GROESBECK required a seatbelt while in a wheelchair for safety;
>
> c. Negligently allowed LORETTA GROESBECK to ambulate or walk, which a reasonably careful person would not do where LORETTA GROESBECK had a problem with bed mobility and positioning;
>
> ***8** d. Negligently allowed LORETTA GROESBECK to ambulate or walk, which a reasonably careful person would not do where LORETTA GROESBECK had balance deficits;
>
> e. Negligently allowed LORETTA GROESBECK to ambulate or walk, which a reasonably careful person would not do where LORETTA GROESBECK had abnormal mobility;
>
> f. Negligently allowed LORETTA GROESBECK to ambulate or walk, which a reasonably careful person

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would not do where LORETTA GROESBECK was complaining of being dizzy on February 1, 2007, and was having a problem with dizziness;

g. Negligently failed to recognize that allowing a person in LORETTA GROESBECK'S condition to walk was simply unsafe and dangerous, which a reasonably careful person would have recognized;

h. Negligently failed to secure or hold LORETTA GROESBECK while she was allowed to walk or ambulate, so as to prevent her from falling, where a reasonably careful person would have secured or held her under such circumstances;

i. Negligently failed to catch or assist LORETTA GROESBECK when she became dizzy and was falling, and/or negligently failed to be in a close enough position to catch or assist her when she began to fall, where a reasonably careful person would have caught or assisted her, and would have been in a position to catch or assist her, under such circumstances.

j. Negligently failed to obtain further help or assistance from additional persons or staff to assist in the subject event, where a reasonably careful person would have sought such additional help or assistance.

In addition, plaintiff's experts testified that Karunakar's actions involved medical judgment. Leonard Elbaum testified that he did not necessarily take issue with Karunakar's decision to perform the gait assessment, but that Karunakar was negligent in executing the assessment. Conversely, Paul Roubal took issue with Karunakar's decision to even conduct a gait assessment:

A. Because I felt as though the therapist, after she finished the evaluation and had come up with a poor to fair sitting balance and then a, very simply, poor standing balance, that it was inappropriate for her to initiate gait training on that day when she had at least a two week window to work towards that and that was one of the recommendations by the physiatrist.

Q. Ms. Karunakar did not violate the standard of care in her evaluation, is that fair?

A. Not from what I could see in the evaluation, no.

Q. Okay. And what you're—if I understand what you're saying, it is her exercise of her judgment in implementing gait training based upon the evaluation?

A. Yes, sir.

Again, while a juror might have some basic knowledge that a certain degree of care would be needed in dealing with an elderly, infirm patient with balance issues, Karunakar utilized her medical or professional judgment in assessing Loretta and in implementing the gait evaluation, causing it to fall within the definition of medical malpractice, not ordinary negligence. Plaintiff's own experts testified that Karunakar exercised professional medical judgment (improvidently or not) in determining whether to perform a gait assessment and in executing the gait assessment. There is simply no way for plaintiff to avoid the conclusion that the claims sound in medical malpractice, regardless of artful wording and argument. Accordingly, the trial court clearly erred in failing to grant defendant summary disposition on plaintiff's ordinary negligence claim.

IV. RES IPSA LOQUITUR

***9** Defendant next argues that the trial court erred in denying defendant summary disposition on plaintiff's res ipsa loquitur claim. We agree.

Proof of negligent conduct can be established by a permissible inference of negligence from circumstantial evidence. To invoke the doctrine of res ipsa loquitur, a plaintiff must show: (1) that the event was of a kind that ordinarily does not occur in the absence of negligence; (2) that it was caused by an agency or instrumentality within the exclusive control of the defendant; (3) that it was not due to any voluntary action of the plaintiff; and (4) that evidence of the true explanation of the event was more readily accessible to the defendant than to the plaintiff. *Woodard v. Custer,* 473 Mich. 1, 6–7, 702 N.W.2d 522 (2005). "[I]f a medical malpractice case satisfies the requirements of the doctrine of res ipsa loquitur, then such case may proceed to the jury without expert testimony." *Id.* at 6, 702 N.W.2d 522.

Plaintiff's own expert Leonard Elbaum admitted that physical therapy patients can fall during gait assessment or gait training without any negligence being committed by

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the physical therapist. The fact that a patient falls during gait assessment did not mean that the therapist violated the standard of care. Elbaum testified:

> *Q.* ... Falls do occur during physical therapy, during gait training, during gait assessment?
>
> *A.* Unfortunately they do, yes.
>
> *Q.* And you're not saying that just because somebody falls and injures themselves during a gait assessment and gait training, that that means the therapist violated the standard of care?
>
> *A.* No, I'm certainly not saying that in every instance.
>
> *Q.* Where the use of a gait belt is appropriate in gait training or gait assessment, the idea is that if the patient does lose his or her balance, the therapist can attempt to steady the patient by hands-on contact; correct?
>
> *A.* Yes.

* * *

> *Q.* And unfortunately a physical therapist, under some circumstances, can be using appropriate parameters for guarding, and the patient suddenly falls and unfortunately the fall occurs and the patient can be injured?
>
> *A.* It's possible you can do the very best you can and still have someone injure themselves during a fall, yes.

Therefore, plaintiff is unable to demonstrate that the event was of a kind that ordinarily does not occur in the absence of negligence. Falling could occur in the absence of any negligence and was a potential consequence of receiving physical therapy. In a medical malpractice case, more than an adverse or bad result is required; while an adverse result may be offered to the jury as part of the evidence of negligence, it does not, standing alone, create an issue for the jury. *Jones,* 428 Mich. at 154, 156, 405 N.W.2d 863.

Additionally, the doctrine of res ipsa loquitur "entitles a plaintiff to a permissible inference of negligence from circumstantial evidence ... when the plaintiff is unable to prove the actual occurrence of a negligent act." *Id.* at 150, 405 N.W.2d 863. Res ipsa loquitur permits proof by circumstantial inferences rather than direct evidence. Plaintiff has pointed to a variety of negligent acts or omissions that allegedly caused Loretta to fall. Thus, plaintiff is not trying to avail himself of res ipsa loquitur to permit an inference of negligence when the true cause is unknown, which is the rationale behind the rule. *Id.* Accordingly, the trial court clearly erred in denying defendant's motion for summary disposition as to plaintiff's res ipsa loquitur claim.

***10** Reversed and remanded for further proceedings not inconsistent with this opinion. We do not retain jurisdiction.

BECKERING, J. (concurring in part and dissenting in part).

I concur in part and dissent in part. At the heart of this appeal is whether plaintiff has stated claims that sound in ordinary or medical negligence associated with 86–year–old Loretta Groesbeck's fall while undergoing physical rehabilitation at defendant's facility. Plaintiff claims that physical therapist Esther Karunakar acted negligently in several distinct ways: (1) by allowing Groesbeck to walk for a gait assessment despite her present physical condition, (2) by failing to secure or hold Groesbeck to prevent her from falling as she walked, and (3) by failing to catch or assist Groesbeck when she became dizzy and fell. The majority concludes that plaintiff's claim that Karunakar negligently allowed Groesbeck to walk for a gait assessment sounds in medical malpractice. I agree. The majority further concludes that plaintiff's claims that Karunakar negligently failed to secure or hold Groesbeck and to catch or assist Groesbeck when she became dizzy and fell likewise sound in medical malpractice. I respectfully disagree. Resolution of the issue of whether Karunakar acted reasonably when she failed to hold Groesbeck securely and allowed her to fall onto the floor is within an ordinary juror's common knowledge and experience and, thus, sounds in ordinary negligence.

It is well established that "[t]he fact that an employee of a licensed health care facility was engaging in medical care at the time the alleged negligence occurred means that the plaintiff's claim may *possibly* sound in medical malpractice; it does not mean that the plaintiff's claim *certainly* sounds in medical malpractice." *Bryant v. Oakpointe Villa Nursing Centre, Inc,* 471 Mich. 411, 421, 684 N.W.2d 864 (2004). To determine whether a claim sounds in ordinary negligence or medical malpractice, a court must consider two questions: "(1) whether the

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claim pertains to an action that occurred within the course of a professional relationship and (2) whether the claim raises questions of medical judgment beyond the realm of common knowledge and experience." *Id* . at 422, 684 N.W.2d 864. If both questions are answered affirmatively, then the claim sounds in medical malpractice. *Id.* "If the reasonableness of the health care professionals' action can be evaluated by lay jurors, on the basis of their common knowledge and experience, it is ordinary negligence." *Id.* at 423, 684 N.W.2d 864.

In *Bryant,* our Supreme Court concluded that a single count of ordinary negligence can contain both ordinary-negligence and medical-malpractice claims. See *id.* at 414, 417–418, 424–432, 684 N.W.2d 864. On the day before the decedent's injury in *Bryant,* nurses discovered the decedent, who had no control over her locomotive skills and, therefore, was at risk for suffocation by positional asphyxia, lying in her bed very close to the bed rails and tangled in her restraining vest, gown, and bed sheets. *Id.* at 415–416, 684 N.W.2d 864. The nurses untangled the decedent and attempted to position bed wedges onto the decedent's bed; however, the bed wedges would not work properly, so the nurses informed their supervisor. *Id.* at 416, 684 N.W.2d 864. The next day, the decedent slipped between the bedrails such that the lower half of her body was on the floor and her neck was wedged between the rail and the mattress, which prevented her from breathing and ultimately caused her death by positional asphyxia. *Id.* at 417, 684 N.W.2d 864. In a single count of ordinary negligence, the plaintiff alleged that the defendant was negligent in four distinct ways:

> ***11** (1) by failing to provide "an accident-free environment" for [the decedent]; (2) by failing to train its Certified Evaluated Nursing Assistants (CENAs) to recognize and counter the risk of positional asphyxiation posed by bed rails; (3) by failing to take adequate corrective measures after finding [the decedent] entangled in her bedding on the day before her asphyxiation; and (4) by failing to inspect plaintiff's bed arrangements to ensure "that the risk of positional asphyxia did not exist for plaintiff's decedent." [*Id.* at 414, 684 N.W.2d 864.]

The Court first concluded that the plaintiff's accident-free-environment claim sounded neither in ordinary negligence nor in medical malpractice but, rather, in strict liability. *Id.* at 425, 684 N.W.2d 864. The Court then concluded that plaintiff's claims for failures to train and inspect sounded in medical malpractice because they required a fact finder to rely on expert testimony where both claims involved a risk assessment of positional asphyxiation posed by bed rails and other restraints, which is beyond the realm of common knowledge. *Id.* at 428–430, 684 N.W.2d 864. However, the Court concluded that the failure-to-take-corrective-measures claim sounded in ordinary negligence. *Id.* at 430, 684 N.W.2d 864. The Court explained,

> No expert testimony is required here in order to determine whether defendant was negligent in failing to respond after its agents noticed that [the decedent] was at risk of asphyxiation. Professional judgment might be implicated if plaintiff alleged that defendant responded inadequately, but, given the substance of plaintiff's allegation in this case, the fact-finder need only determine whether *any* corrective action to reduce the risk of recurrence was taken after defendant's agents noticed that [the decedent] was in peril. [*Id.* at 431, 684 N.W.2d 864.]

The majority discusses *Bryant* at length but, in my view, fails to appreciate that plaintiff's single count of ordinary negligence can and does contain both ordinary-negligence and medical-malpractice claims. More specifically, the majority opines that

> plaintiff hastily notes in his appellate brief that the "crux of this lawsuit" is that Karunakar "failed to carefully hold Ms. Groesbeck to prevent her from falling." However, a clear reading of the complaint belies that notion. Plaintiff plainly takes issue with Karunaker's decision to conduct the gait assessment in the first place.

Although the majority is correct that a clear reading of plaintiff's complaint demonstrates that plaintiff takes issue with Karunaker's decision to conduct the gait assessment, which I conclude as the majority does is a claim sounding in medical malpractice, plaintiff's allegation that Karunakar negligently decided to conduct the gait assessment does not make plaintiff's ordinary-negligence count sound entirely in medical malpractice. See *id.* at 414, 417–418, 424–432, 684 N.W.2d 864. Rather,

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plaintiff's claims that Karunakar failed to hold Groesbeck securely and allowed her to fall onto the floor must be evaluated separately from plaintiff's claim regarding Karunakar's decision to conduct the gait assessment to determine whether it sounds in medical malpractice or ordinary negligence. See *id.* at 424–425, 684 N.W.2d 864.

***12** In evaluating plaintiff's claims that Karunakar failed to hold Groesbeck securely and allowed her to fall onto the floor, I find instructive this Court's opinion in *Sheridan v. West Bloomfield Nursing & Convalescent Center, Inc,* unpublished opinion per curiam of the Court of Appeals, issued March 6, 2007 (Docket No. 272205). Although *Sheridan* is unpublished and, thus, not binding on this Court, MCR 7.215(C)(1), I consider it to have great persuasive value given its factual similarity to this case, and I would apply this Court's reasoning in *Sheridan* when evaluating plaintiff's claims, see *Paris Meadows, LLC v. City of Kentwood,* 287 Mich.App. 136, 145 n. 3, 783 N.W.2d 133 (2010). In *Sheridan,* the plaintiff alleged that the defendants were negligent "when two nurse assistants dropped plaintiff's decedent while moving her from her bed to a wheel chair using a 'gait belt.' " *Sheridan,* unpub op at 2. The plaintiff did not challenge the defendants' decision to move the decedent, the decision to use a gait belt, or the manner in which the gait belt was fastened to the decedent. *Id.* Rather, the only claim of negligence raised by the plaintiff was whether the defendants, after they decided to use the gait belt and secured the decedent with it, "acted reasonably when they failed to maintain a secure grip on plaintiff's decedent and dropped her or allowed her to fall on the floor." *Id.* This Court concluded that the plaintiff's claim sounded in ordinary negligence, explaining that "[r]esolution of this issue is within the common knowledge and experience of an ordinary juror and does not require expert testimony concerning the exercise of medical judgment." *Id.*

Similar to the plaintiff's claim against the nurse assistants in *Sheridan,* plaintiff's claims in this case are whether Karunakar acted reasonably when she failed to hold Groesbeck securely and allowed her to fall onto the floor. As in *Sheridan,* resolution of these claims is "within the common knowledge and experience of an ordinary juror and does not require expert testimony concerning the exercise of medical judgment." *Id.* When Groesbeck entered defendant's facility, she was 86 years old, weighed just over 110 pounds, and had just suffered a minor stroke. On the morning of her first day with defendant, she was vomiting, dizzy, and had difficulty standing. Several hours later, she was able to move in a wheelchair and stand for a short period of time. Karunakar then decided to allow Groesbeck to walk with a pyramid walker for a gait assessment. She fastened a gait belt around Groesbeck's waist and held the belt with one hand while dragging a wheelchair in her other hand. After taking three steps, Groesbeck stated that she was dizzy, fell to the floor, and hit her head. Expert testimony is not required for an ordinary juror to determine whether Groesbeck acted negligently by failing to hold Groesbeck securely and allowing her to fall onto the floor. See *id.;* see also *Fogel v. Sinai Hosp. of Detroit,* 2 Mich.App. 99, 101–102, 138 N.W.2d 503 (1965) (claim sounds in ordinary negligence where hospital patient falls while walking to the bathroom with a nurse's assistance); *Gold v. Sinai Hosp. of Detroit, Inc.,* 5 Mich.App. 368, 369–370, 146 N.W.2d 723 (1966) (claim sounds in ordinary negligence where nauseated and dizzy hospital patient falls while being assisted from a seated position onto an examination table by a nurse who braced the patient from behind).

***13** The majority opines that *Sheridan* is distinguishable from the present case in one critical respect: the plaintiff in *Sheridan* was not challenging the decision to move the decedent, the decision to use the gait belt, or the manner in which the gait belt was fastened. I fail to see the critical nature of this distinguishing fact. Indeed, it is irrelevant to whether plaintiff's claims that Karunakar failed to hold Groesbeck securely and allowed her to fall onto the floor sound in medical malpractice or ordinary negligence. As previously discussed, *Bryant* makes clear that a plaintiff's single count of ordinary negligence can contain both ordinary-negligence and medical-malpractice claims. *Bryant,* 471 Mich. at 414, 417–418, 424–432, 684 N.W.2d 864. Thus, plaintiff's claim that Karunakar was negligent by allowing Groesbeck to walk for a gait assessment has no bearing on whether plaintiff's claims that Karunakar failed to hold Groesbeck securely and allowed her to fall onto the floor sound in medical malpractice or ordinary negligence; the claims must be evaluated separately. See *id.* at 424–425, 684 N.W.2d 864.

The majority also opines that plaintiff's claims that Karunakar negligently failed to hold Groesbeck securely and allowed her to fall onto the floor are a claim that Karunakar failed to take "adequate or reasonable precautions to prevent [Groesbeck] from falling during the assessment." According to the majority,

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Karunakar exercised medical judgment when deciding what precautions to take when allowing Groesbeck to walk, i.e., what guarding method to implement when executing the gait assessment. Thus, the majority concludes that Karunakar's use of knowledge beyond the realm of common knowledge and experience establishes that plaintiff's claims sound in medical malpractice. I agree that a physical therapist exercises medical judgment when deciding what guarding method to implement, including whether a gait belt should be used. And, I also agree that a physical therapist exercises medical judgment when conducting a gait assessment. However, I disagree for several reasons with the majority's conclusion that plaintiff's claims sound in medical malpractice on this basis. First, aside from plaintiff's claim that Karunakar negligently allowed Groesbeck to walk, the remaining claims in plaintiff's ordinary-negligence count raise the same allegation as the plaintiff did in *Sheridan:* negligence by failing to hold a patient securely and allowing the patient to fall. None of the claims in plaintiff's ordinary-negligence count take issue with Karunakar's decision to use the gait belt as a precaution for Groesbeck. Second, plaintiff's claims that Karunakar failed to hold Groesbeck securely and allowed her to fall onto the floor do not sound in medical malpractice simply because Karunakar exercised medical judgment during the gait assessment. Rather, the appropriate inquiry is whether the reasonableness of Karunakar's action can be evaluated by lay jurors on the basis of their common knowledge and experience. See *id.* at 423, 684 N.W.2d 864. The fact that a health-care professional exercises medical judgment when committing a negligent act does not prohibit lay jurors from evaluating on the basis of common knowledge and experience the reasonableness of the health-care professional's action; for example, surgeons certainly exercise medical judgment while performing surgery, but, "if a foreign object is left within the body of a patient on whom an operation has been performed, to his injury, laymen may properly decide the question of negligence without the aid of experts." *Roberts v. Young,* 369 Mich. 133, 138, 119 N.W.2d 627 (1963), citing *Wood v. Vroman,* 226 Mich. 625, 198 N.W. 228 (1924); *LeFaive v. Asselin,* 262 Mich. 443, 247 N.W. 911 (1933); *Taylor v. Milton,* 353 Mich. 421, 92 N.W.2d 57 (1958). Finally, although Karunakar used medical judgment for the gait assessment, lay jurors using common knowledge and experience can determine without expert testimony whether Karunakar acted unreasonably by holding onto Groesbeck—an 86–year–old, 110–pound, first-day-rehabilitation patient who had just suffered a minor stroke and had a history just several hours earlier of vomiting, dizziness, and difficulty standing—with only one hand as Groesbeck walked and by allowing Groesbeck to fall.

***14** For these reasons, I respectfully dissent from the majority's holding that plaintiff's ordinary-negligence count sounds entirely in medical malpractice.

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EXHIBIT 2

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2004 WL 2009264
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UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Court of Appeals of Michigan.

Sandra CAMPINS, Plaintiff-Appellant,
v.
SPECTRUM HEALTH DOWNTOWN CAMPUS, Defendant-Appellee.

No. 247024.
|
Sept. 9, 2004.

Before: DONOFRIO, P.J. and WHITE and TALBOT, JJ.

[UNPUBLISHED]

DONOFRIO, WHITE and TALBOT, JJ.

MEMORANDUM.

***1** Plaintiff appeals as of right the trial court's order granting defendant's motion for summary disposition and dismissing this case with prejudice. We affirm. This appeal is being decided without oral argument pursuant to MCR 7.214(E).

Plaintiff was treated at defendant's facility for a broken pubic bone. She filed suit alleging that defendant's employee acted negligently in assisting her in moving from the bathroom to her bed, in dealing with her port-a-cath, and in administering a heparin treatment to her in her vehicle. Defendant moved for summary disposition pursuant to MCR 2.116(C)(7), (8), and (10), arguing that plaintiff's claim was actually one for medical malpractice, that she failed to file a notice of intent and affidavit of merit as required by MCL 600.2912b and MCL 600.2912d(1), and that upon dismissal of the complaint, plaintiff's claim would be barred by the statute of limitations. MCL 600.5805(6). The trial court granted the motion, finding that plaintiff's injury occurred during the course of her professional relationship with defendant.

We review a trial court's decision on a motion for summary disposition de novo. *Auto Club Group Ins Co v. Burchell,* 249 Mich.App 468, 479; 642 NW2d 406 (2001).

The key to whether a claim sounds in medical malpractice is whether the negligence occurred within the course of a professional relationship in which medical treatment was rendered. Whether a claim sounds in medical malpractice depends on whether the facts alleged raise issues that are within common knowledge and experience or raise questions involving medical judgment. *Dorris v Detroit Osteopathic Hosp Corp,* 460 Mich. 26, 46-47; 594 NW2d 455 (1999); *Regalski v. Cardiology Assocs, PC,* 459 Mich. 891; 587 NW2d 502 (1998).

Plaintiff argues that the trial court erred by granting defendant's motion for summary disposition. She asserts that in this case, as in *Gold v. Sinai Hosp,* 5 Mich.App 368; 146 NW2d 723 (1966), *Fogel v. Sinai Hosp,* 2 Mich.App 99; 138 NW2d 503 (1965), and *DiGiovanni v. St. John Health System,* unpublished opinion per curiam of the Court of Appeals, issued October 30, 1998 (Docket No. 200398), the allegations presented issues within common knowledge and experience, and that a jury would not need expert testimony to assist it in determining that defendant's employee acted negligently. We disagree and affirm. The acts that formed the basis of plaintiff's complaint occurred in the context of plaintiff's professional relationship with defendant. Plaintiff was hospitalized for treatment of a broken pubic bone. The act of assisting a patient in plaintiff's condition in moving required training and the exercise of medical judgment to minimize discomfort and to guard against further injury. The acts of tending to a port-a-cath and administering a heparin treatment required training and the exercise of medical judgment. The trial court correctly concluded that *Dorris, supra,* controlled, and that plaintiff's complaint sounded in medical malpractice. Summary disposition was proper. MCL 600.5805(6).

***2** Affirmed.

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EXHIBIT 3

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2003 WL 22850024
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UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Court of Appeals of Michigan.

Nancy E. LEWANDOWSKI, Plaintiff-Appellant,
v.
MERCY MEMORIAL HOSPITAL CORPORATION, d/b/a Mercy Memorial Health System, Defendant-Appellee.

No. 241046.
|
Dec. 2, 2003.

Before: MURRAY, P.J., and GAGE and KELLY, JJ.

[UNPUBLISHED]

PER CURIAM.

***1** Plaintiff appeals as of right the trial court's order granting defendant's motion for summary disposition and dismissing the case with prejudice. We affirm. This appeal is being decided without oral argument pursuant to MCR 7.214(E).

Plaintiff was admitted to defendant's facility for treatment of a head injury. Plaintiff alleges in her complaint that defendant's employees were assisting her in getting dressed so that she could leave the facility, and told her that she should stand. She objected to doing so on the grounds that she had not put weight on her feet for several months, and that it was against her physician's orders. Plaintiff's protests notwithstanding, defendant's employees stood her on her feet. She collapsed to the floor and fractured her left leg. Plaintiff filed suit alleging that defendant's employees acted negligently in attempting to have her stand against her physician's orders.

Defendant moved for summary disposition pursuant to MCR 2.116(C)(8), arguing that plaintiff's claim was actually one for medical malpractice. In response, plaintiff argued that the claim sounded in ordinary negligence rather than medical malpractice because defendant's employees did not render medical care.

The trial court granted defendant's motion for summary disposition and dismissed the case without prejudice. [1] The trial court found that plaintiff's injury occurred during the course of her professional relationship with defendant. The court further found that the record supported a finding that plaintiff's injury occurred when she was being assisted by nurses using a specific lift technique and a walker, and that the issue of whether defendant's employees acted negligently required expert testimony. Thus, the trial court held that plaintiff was required to file the case as a medical malpractice action.

1 The trial court's decision indicates that it granted summary disposition under MCR 2.116(C)(8); however, the court considered material beyond the pleadings in rendering its decision. Under the circumstances, we review the court's decision as having been granted under MCR 2.116(C)(10). *Detroit News, Inc v Policemen & Firemen Retirement System of Detroit,* 252 Mich.App 59, 66; 651 NW2d 127 (2002).

We review a trial court's decision on a motion for summary disposition de novo. *Auto Club Group Ins Co v. Burchell,* 249 Mich.App 468, 479; 642 NW2d 406 (2001).

The key to whether a claim sounds in medical malpractice is whether it is alleged that the negligence occurred within the course of a professional relationship in which medical care and treatment was rendered. Whether a claim sounds in medical malpractice depends on whether the facts alleged raise issues that are within common knowledge and experience or raise questions involving medical judgment. *Dorris v Detroit Osteopathic Hosp Corp,* 460 Mich. 26, 46-47; 594 NW2d 455 (1999); *Regalski v. Cardiology Associates, PC,* 459 Mich. 891; 587 NW2d 502 (1998).

Plaintiff argues that the trial court erred by granting defendant's motion for summary disposition. She contends that her claim sounded in ordinary negligence because it did not allege that defendant's employees rendered medical care or treatment when attempting to stand her on her feet. We disagree. Plaintiff's reliance on *Gold v. Sinai Hosp,* 5 Mich.App 368; 146 NW2d 723 (1966), *Fogel v. Sinai Hosp,* 2 Mich.App 99; 138 NW2d 503 (1965), and *DiGiovanni v. St. John Health*

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System, unpublished opinion per curiam of the Court of Appeals, issued October 30, 1998 (Docket No. 200398), is misplaced. In those cases, claims of ordinary negligence were permitted to proceed against the defendant hospitals where patients were injured while being assisted in movement by a hospital employee. However, those cases did not involve health care workers acting in accordance with specific orders from a physician.

***2** In this case, the act that formed the basis of plaintiff's complaint occurred in the context of plaintiff's professional relationship with defendant. *Dorris, supra.* Plaintiff's physician had ordered that nurses were to assist plaintiff in moving to a specialized chair and in getting some form of exercise twice per day. The act of assisting a patient in plaintiff's condition, i.e., recovering from a head injury and bedridden for a prolonged period of time, to stand or to move from a bed to a chair required training and the exercise of medical judgment both to minimize plaintiff's discomfort and to guard against further injury. The trial court correctly determined that plaintiff's complaint sounded in medical malpractice rather than in ordinary negligence, *Dorris, supra; Regalski, supra,* and that plaintiff was required to file suit in accordance with the notice and waiting period provisions applicable to medical malpractice actions. The trial court properly granted defendant's motion for summary disposition.

Affirmed.

All Citations

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